

Facility Name & ID Number Manorcare at Westmont# 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,510</u>	<u>12,929</u>	<u>23,450</u>	<u>50,889</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,510</u>	<u>12,929</u>	<u>23,450</u>	<u>50,889</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.95%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 155 and days of care provided 19,597Medicare Intermediary Highmark Medicare Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/05 Fiscal Year: 05/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Manorcare at Westmont

0019489

Report Period Beginning:

06/01/04

Ending:

05/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	349,286	26,044	1,926	377,256	3,433	380,689		380,689			1
2	Food Purchase		229,327		229,327		229,327	(429)	228,898			2
3	Housekeeping	182,525	28,708	3,539	214,772		214,772		214,772			3
4	Laundry	58,345	22,207	7,336	87,888		87,888		87,888			4
5	Heat and Other Utilities			177,997	177,997	7,919	185,916		185,916			5
6	Maintenance	43,729	30,628	69,567	143,924		143,924		143,924			6
7	Other (specify):* Medical Waste			3,652	3,652		3,652		3,652			7
8	TOTAL General Services	633,885	336,914	264,017	1,234,816	11,352	1,246,168	(429)	1,245,739			8
	B. Health Care and Programs											
9	Medical Director			33,030	33,030		33,030		33,030			9
10	Nursing and Medical Records	3,503,984	258,720	34,994	3,797,698	58,548	3,856,246		3,856,246			10
10a	Therapy	505,272	11,443	530,146	1,046,861		1,046,861		1,046,861			10a
11	Activities	102,480	5,512	2,075	110,067		110,067		110,067			11
12	Social Services	60,208		400	60,608		60,608		60,608			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,171,944	275,675	600,645	5,048,264	58,548	5,106,812		5,106,812			16
	C. General Administration											
17	Administrative	78,433		459,726	538,159	(147,138)	391,021		391,021			17
18	Directors Fees											18
19	Professional Services			17,741	17,741		17,741	(17,741)				19
20	Dues, Fees, Subscriptions & Promotions			107,832	107,832		107,832	(52,729)	55,103			20
21	Clerical & General Office Expenses	434,233	51,751	172,601	658,585		658,585	(115,962)	542,623			21
22	Employee Benefits & Payroll Taxes			839,048	839,048	53,826	892,874		892,874			22
23	Inservice Training & Education			2,189	2,189		2,189		2,189			23
24	Travel and Seminar			3,328	3,328		3,328		3,328			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			173,856	173,856		173,856		173,856			26
27	Other (specify):* Purch. Serv. Admin.			190	190		190	(190)				27
28	TOTAL General Administration	512,666	51,751	1,776,511	2,340,928	(93,312)	2,247,616	(186,622)	2,060,994			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,318,495	664,340	2,641,173	8,624,008	(23,412)	8,600,596	(187,051)	8,413,545			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Manorcare at Westmont

#0019489

Report Period Beginning:

06/01/04

Ending:

05/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			507,640	507,640	23,412	531,052		531,052			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			108,606	108,606		108,606		108,606			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			100,370	100,370		100,370		100,370			35
36	Other (specify):* Gain/Loss on Assets			1,487	1,487		1,487	(1,487)				36
37	TOTAL Ownership			718,103	718,103	23,412	741,515	(1,487)	740,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,157	1,157		1,157		1,157			38
39	Ancillary Service Centers		594,145		594,145		594,145		594,145			39
40	Barber and Beauty Shops		430	19,512	19,942		19,942		19,942			40
41	Coffee and Gift Shops	15,371			15,371		15,371		15,371			41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):* IV X-Ray & Lab		151,039	91,846	242,885		242,885		242,885			43
44	TOTAL Special Cost Centers	15,371	745,614	197,379	958,364		958,364		958,364			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,333,866	1,409,954	3,556,655	10,300,475		10,300,475	(188,538)	10,111,937			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/04

Ending: 05/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care	\$	10	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(429)	2	4
5	Telephone, TV & Radio in Resident Rooms	(9,217)	21	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation		30	9
10	Interest and Other Investment Income		32	10
11	Discounts, Allowances, Rebates & Refunds		21	11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(295)	21	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)	(190)	27	16
17	Non-Care Related Fees			17
18	Fines and Penalties	(180)	21	18
19	Entertainment			19
20	Contributions		21	20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers	(17,741)	19	22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(102,743)	21	24
25	Fund Raising, Advertising and Promotional	(52,729)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	CNA Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule	(5,014)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (188,538)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)		34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (188,538)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38		X	\$		38
39					39
40		X			40
41		X			41
42		X			42
43		X			43
44		X			44
45					45
46					46
47			\$		47

Manorcare at WestmontID# 0019489Report Period Beginning: 06/01/04Ending: 05/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,791)	21	1
2	Misc. Income	(1,736)	21	2
3	Loss of Disposal of Fixed Asset	(1,487)	36	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(5,014)		49

Summary A

05/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/04

Ending:

05/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 459,726		HCR Manor Care, Inc.	100.00%	\$ 459,726		1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Therapy Management	41,068		Heartland Management Services	100.00%	41,068		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$ 500,794				\$ 500,794	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/04Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.Street Address 333 North Summit St.City / State / Zip Code Toledo, OH 43604-2617Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u>	<u>Dietary - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>\$</u>	<u>\$</u>	<u>0</u>	1
2	<u>1</u>	<u>Dietary - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>1,043,233</u>	<u>571,891</u>	<u>9,309,004</u>	2
3	<u>5</u>	<u>Utilities - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>223,707</u>		<u>9,309,004</u>	3
4	<u>5</u>	<u>Utilities - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>2,139,042</u>		<u>9,309,004</u>	4
5	<u>10</u>	<u>Nursing - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>12,987,607</u>	<u>8,226,246</u>	<u>9,309,004</u>	5
6	<u>10</u>	<u>Nursing - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>2,252,260</u>	<u>1,199,059</u>	<u>9,309,004</u>	6
7	<u>17</u>	<u>General & Admin - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>16,611,639</u>	<u>15,056,893</u>	<u>9,309,004</u>	7
8	<u>17</u>	<u>General & Admin - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>75,121,310</u>	<u>43,509,256</u>	<u>9,309,004</u>	8
9	<u>22</u>	<u>Employee Benefits - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>3,924,545</u>		<u>9,309,004</u>	9
10	<u>22</u>	<u>Employee Benefits - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>11,662,215</u>		<u>9,309,004</u>	10
11	<u>30</u>	<u>Depreciation - Direct</u>	<u>Accumulated Cost</u>	<u>2,364,266,309</u>	<u>369 Nurs. Fac.</u>	<u>0</u>		<u>9,309,004</u>	11
12	<u>30</u>	<u>Depreciation - Pooled</u>	<u>Accumulated Cost</u>	<u>2,829,104,777</u>	<u>369 Nurs. Fac.</u>	<u>7,114,804</u>		<u>9,309,004</u>	12
13									13
14	<u>32</u>	<u>Interest</u>				<u>10,002,527</u>		<u>0</u>	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					<u>\$ 143,082,889</u>	<u>\$ 68,563,345</u>	<u>\$ 459,726</u>	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Westmont COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019489

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419) 252-5731 FAX #: (419) 254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>09-03-207-014</u>	<u>See Attached</u>	\$ <u>100,796.64</u>	\$ <u>100,796.64</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>100,796.64</u></u>	\$ <u><u>100,796.64</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A.

Square Feet:

39,189

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

2

C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1977	\$ 195,699	1
2	Facility addition		2004	33,809	2
3	TOTALS			\$ 229,508	3

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning:

06/01/04

Ending:

05/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	155		1977	\$ 1,372,073	\$ 56,883		\$ 56,883		\$ 1,015,376
5			2004	1,903,806					
6									
7									
8									
Improvement Type**									
9	Current Year Depreciation				331,118		331,118		1,647,078
10			1985	42,165					
11			1986	9,808					
12			1987	118,541					
13			1988	118,593					
14			1989	58,768					
15			1990	15,910					
16			1991	58,674					
17			1992	84,338					
18			1993	50,656					
19			1994	697,677					
20			1995	184,192					
21			1996	118,190					
22			1997	90,456					
23			1998	253,224					
24			1999	3,181					
25			2000	85,888					
26			2001	224,426					
27	VINYL WALLCOVERING		2002	1,404					
28	WINDOW TREATMENTS		2002	907					
29	PAINT, WVC, & CARPET		2002	8,512					
30	INSTALL PHONE JACKS		2002	476					
31	ELECTRIC WORK & FIXTURES		2002	2,699					
32	CONSTRUCTION OF NEW INTERIOR WALL		2002	1,930					
33	CONCRETE / RETAINING WALL		2002	11,871					
34	STORAGE ROOM		2003	6,740					
35	VINYL WALLCOVERING		2003	7,131					
36	CARPET		2003	1,744					

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

05/31/05

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,468,909	\$ 119,639	\$ 119,639	\$		\$ 1,166,469	71
72	Current Year Purchases	500,675						72
73	Fully Depreciated Assets							73
74	Retirement & Home Office Depr	(5,100)		23,412	23,412		(3,614)	74
75	TOTALS	\$ 1,964,484	\$ 119,639	\$ 143,051	\$ 23,412		\$ 1,162,855	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,442,204	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 507,640	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 531,052	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 23,412	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,825,309	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 100,370 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$ _____

13. /2007 \$ _____

14. /2008 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10a	2909	hrs	\$ 88,414	4,766	\$ 217,421	\$ 2,007	7,675	\$ 307,842	1
2	Licensed Speech and Language Development Therapist	10a	1101	hrs	34,765	758	34,598	597	1,859	69,960	2
3	Licensed Recreational Therapist			hrs		3	159		3	159	3
4	Licensed Physical Therapist	10a	3193	hrs	102,646	5,111	233,184	8,839	8,304	344,669	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				594,145		594,145	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-ray & Lab	43, 3					91,846			91,846	13
14	TOTAL				\$ 225,825	10,639	\$ 577,208	\$ 605,588	17,842	\$ 1,408,621	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 30,798	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 251,612)	2,152,194		3
4	Supply Inventory (priced at 03/31/05)	41,136		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	77,265		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,301,393	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	229,508		13
14	Buildings, at Historical Cost	7,248,212		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,964,484		16
17	Accumulated Depreciation (book methods)	(3,825,309)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction In Progress	15,300		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,632,195	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,933,588	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,973	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	396,057		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,237		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	94,661		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 715,928	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 715,928	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 7,217,660	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,933,588	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,809,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,809,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,565,813	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,565,813	17
	B. Transfers (Itemize):		
18	Changes in Interdivison	(2,157,675)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,157,675)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,217,660	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/04

Ending:

05/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,602,989	1
2	Discounts and Allowances for all Levels	(2,017,147)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,585,842	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,553,116	6
7	Oxygen	8,242	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,561,358	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,767	12
13	Barber and Beauty Care	22,656	13
14	Non-Patient Meals	429	14
15	Telephone, Television and Radio	9,297	15
16	Rental of Facility Space		16
17	Sale of Drugs	568,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,272	19
20	Radiology and X-Ray	38,705	20
21	Other Medical Services	75	21
22	Laundry	6,471	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 716,721	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	1,736	28
28a	Late Charges	631	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,367	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,866,288	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,234,816	31
32	Health Care	5,048,264	32
33	General Administration	2,340,928	33
B. Capital Expense			
34	Ownership	718,103	34
C. Ancillary Expense			
35	Special Cost Centers	873,500	35
36	Provider Participation Fee	84,864	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,300,475	40
41	Income before Income Taxes (line 30 minus line 40)**	2,565,813	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,565,813	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare at Westmont# 0019489Report Period Beginning: 06/01/04Ending: 05/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,368	2,558	\$ 94,278	\$ 36.86	1
2	Assistant Director of Nursing	5,254	5,676	163,754	28.85	2
3	Registered Nurses	35,214	38,048	1,035,700	27.22	3
4	Licensed Practical Nurses	39,965	43,181	939,714	21.76	4
5	CNAs & Orderlies	100,923	109,052	1,238,758	11.36	5
6	CNA Trainees					6
7	Licensed Therapist	7,184	7,795	245,039	31.44	7
8	Rehab/Therapy Aides	12,636	13,711	260,233	18.98	8
9	Activity Director	8,018	8,693	102,480	11.79	9
10	Activity Assistants					10
11	Social Service Workers	3,699	4,026	60,208	14.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,044	31,502	349,286	11.09	15
16	Dishwashers					16
17	Maintenance Workers	2,133	2,311	43,729	18.92	17
18	Housekeepers	16,649	18,051	182,525	10.11	18
19	Laundry	6,418	6,959	58,345	8.38	19
20	Administrator	2,080	2,080	78,433	37.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,808	24,957	434,233	17.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,350	2,550	31,780	12.46	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,216	1,320	15,371	11.64	33
34	TOTAL (lines 1 - 33)	297,959	322,470	\$ 5,333,866 *	\$ 16.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	33,030	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,595	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,625		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$8241
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$2663
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,890 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,864
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 429
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.